

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont Rt. 2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont R. Rt. 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Robert (Middle) (First) Bentz</u>		4. DATE OF DEATH <u>July 12 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/15/39</u>
9. AGE (In years last birthday) <u>16</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>In School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Thurmont High</u>	
11. BIRTHPLACE (State or foreign country) <u>Thurmont, Md. Rt. #2</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Bentz</u>		14. MOTHER'S MAIDEN NAME <u>Vergie M. Eyler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-3924</u>	
17. INFORMANT <u>John W. Bentz</u>		Address <u>Thurmont, Md. Rt. #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm pond</u>		20f. (City or town) (County) (State) <u>Frederick</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. D. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. D. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Brothers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Thurmont, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Stenger</u>		ADDRESS <u>Thurmont, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>A. H. Search</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

Boy, 16, Drowned In Pond On Farm

Thurmont, Md., July 12 (AP)—Robert John Bentz, 16, was seized with a cramp and drowned while swimming in a farm pond near his home today.

A companion, Harry Francis Portner, 14, tried to rescue Bentz but was unable to hold on to the considerably larger victim.

The body was recovered an hour and a half later and the victim was pronounced dead by the county medical examiner.

BUREAU V. 2

JUL 16 1956

RECEIVED

7224

CERTIFICATE OF DEATH

07163

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNA. b. COUNTY PHILA.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLDFIELDS				c. LENGTH OF STAY IN 1b 6 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION BRIDGE RURAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month JULY Day 14 Year 1956				5. SEX F 6. COLOR OR RACE COL 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. NAME OF DECEASED (Type or print) First MYRTLE Middle LOUISE Last BIGGUS				9. AGE (In years last birthday) 40 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SUMMERFIELD BIGGUS				14. MOTHER'S MAIDEN NAME MARY FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT MRS EVAN VALENTINE				Address MD OLDFIELDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anteroseptal Cardiac Disease (c) Disease INTERVAL BETWEEN ONSET AND DEATH 2 Weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 5, 1956 to July 14, 1956 that I last saw the deceased alive on July 13, 1956 , and that death occurred at 8:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. E. Robertson				ADDRESS (Street, city or town, state) New Windsor, Md.			
PHYSICIAN'S NAME (Type) M. E. Robertson M.D.				DATE SIGNED 7/14/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 17-1956		22c. NAME OF CEMETERY OR CREMATORY KEYS CHAPEL		22d. LOCATION (City, town, or county) (State) FREDERICK CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzler & Sons, New Windsor				24a. REC'D BY REGISTRAR DATE 7/16/56			
				24b. REGISTRAR'S SIGNATURE Leslie L. Reppe			

CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES EARL RAY SEX MALE DATE OF BIRTH JAN 5 1928 PLACE OF BIRTH MOBILE, ALABAMA</p>		<p>DATE OF DEATH JUL 6 1968 PLACE OF DEATH MEMPHIS, TENNESSEE</p>	
<p>CAUSE OF DEATH HEART DISEASE MYOCARDIAL INFARCTION</p>		<p>IMMEDIATE CAUSE CORONARY THROMBOSIS</p>	
<p>INTERVIEWED BY J. H. [illegible]</p>		<p>DATE OF INTERVIEW JUL 10 1968</p>	
<p>SIGNATURE OF DECEASED [illegible]</p>		<p>SIGNATURE OF WITNESS [illegible]</p>	
<p>DATE OF SIGNATURE [illegible]</p>		<p>DATE OF SIGNATURE [illegible]</p>	
<p>PLACE OF SIGNATURE [illegible]</p>		<p>PLACE OF SIGNATURE [illegible]</p>	

BUREAU V. 8

JUL 17 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07164

7186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 56 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nellie K. Blocher		4. DATE OF DEATH Month Day Year July 3 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/88
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Mr. Frank Blocher		14. MOTHER'S MAIDEN NAME Sarah M. Diehl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 20-30-9269A	
17. INFORMANT Frederick Memorial Hospital		Address C. Wood	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE INTESTINAL OBSTRUCTION DUE TO MASSIVE INTRAPERITONEAL ADHESIONS DUE TO MULTIPLE ABDOMINAL OPERATIONS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pyelonephritis; Arterio-sclerotic heart dis.; *		INTERVAL BETWEEN ONSET AND DEATH 5 days ? 15+ YRS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) * Colostomy for Carcinoma of Sigmoid	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 MAY , 19 56 , to 3 JULY , 19 56 , that I last saw the deceased alive on 2 JULY , 19 56 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Conley, Jr. M.D.		ADDRESS (Street, city or town, state) Professional Bldg	
DATE SIGNED 7/3/56			
PHYSICIAN'S NAME (Type) C. H. Conley, Jr., M.D.		FREDERICK, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/56	
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Gettysburg, Adams Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Milton Bender		ADDRESS Gettysburg, Pa.	
24a. REC'D BY REGISTRAR Jul 9 1956		24b. REGISTRAR'S SIGNATURE W. J. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7225

CERTIFICATE OF DEATH

Reg. Dist. No.

97165

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Lewistown				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First J. Middle Vernon Last Boone				4. DATE OF DEATH Month July Day 30 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15-1881	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Used Furniture Dealer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Calvin Boone				14. MOTHER'S MAIDEN NAME Elisa Sickie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-14-9354		17. INFORMANT Chester E. Boone (Son) Thurmont-Md.-Route 1 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Chronic Atherosclerotic 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial degeneration DUE TO (c) 2 yrs.						INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 15 , 19 56 , to July 1 , 19 56 , that I last saw the deceased alive on July 1 , 19 56 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 24 E. Main St.,-Thurmont-Md. DATE SIGNED 7-31-1956							
ACTUAL SIGNATURE James T. Gray				M.D. 24 E. Main St.,-Thurmont-Md.			
PHYSICIAN'S NAME (Type) Dr. J.K. Gray							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2-1956		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Middletown- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR 2 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

0755-1305

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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AUG 3 1956

115

BUREAU V.

7187

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 3 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 235 West South Street			
3. NAME OF DECEASED (Type or print) First ULYSSES Middle GRANT Last BOURNE, SR.				4. DATE OF DEATH Month July Day 15 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 March 1873		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor of Medicine		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME F. Louis Bourne				14. MOTHER'S MAIDEN NAME Margaret Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT 226 West South Street, Dr. U. G. Bourne, Jr. Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension (Probably Carcinoma)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 29, 1956 to July 15, 1956 , that I last saw the deceased alive on July 15, 1956 , and that death occurred at 5:50 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearre			M.D. East Church St., Frederick, Md. DATE SIGNED 7/16/1956				
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre			Same as above				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Fairview Cem.		22d. LOCATION (City, town, or county) (State) Frederick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 15 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Herb	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Frederick		Male		25		1930		Maryland		Frederick		Heart Disease		July 19, 1956		10:00 AM		Frederick		J. H. Smith		J. H. Smith	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Mental State		Manner of Death		Burial Place		Burial Date		Burial Time	
Frederick		High School		Married		None		Occasional		Occasional		None		None		Natural		Frederick		July 20, 1956		10:00 AM	
Signature of Informant		Relationship		Signature of Informant		Relationship		Signature of Informant		Relationship		Signature of Informant		Relationship		Signature of Informant		Relationship		Signature of Informant		Relationship	
J. H. Smith		Wife		J. H. Smith		Wife		J. H. Smith		Wife		J. H. Smith		Wife		J. H. Smith		Wife		J. H. Smith		Wife	

BUREAU V. S.

JUL 20 1956

RECEIVED

07167
131

7188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 6 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 10 South Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CLARA Middle MITCHELL Last BREWER				4. DATE OF DEATH Month July Day 26 Year 1956				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 July 1911		
9. AGE (In years last birthday) yrs. 45		IF UNDER 1 YEAR Months 1 Days 15 Hours 15 Min.		IF UNDER 24 HRS. Months 1 Days 15 Hours 15 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guidance Counselor			10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter A. Brewer				14. MOTHER'S MAIDEN NAME Zella Fore				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Dola M. Schubert, 153 Fitzgerald St., Philadelphia 48, Pa.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma ovarian cyst 175X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 mo							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 26, 1956 , to July 26, 1956 , that I last saw the deceased alive on July 26, 1956 , and that death occurred at 4:35 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE Rex R. Martin				M.D. 35 E. Church St., Frederick, Md. DATE SIGNED 7/27/56				
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 30 July 1956		22c. NAME OF CEMETERY OR CREMATORY Antioch Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Yale, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 28 July 1956		
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Hark				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		Jan 15, 1910	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md.		Heart Disease		Jan 20, 1955		10:00 AM	
Usual Residence		Occupation		Manner of Death		Place of Death	
123 Main St.		Teacher		Natural		Home	
Marital Status		Signature of Physician		Signature of Registrar		Signature of Informant	
Married		[Signature]		[Signature]		[Signature]	
Date of Marriage		Date of Death		Date of Burial		Place of Burial	
1935		Jan 20, 1955		Jan 25, 1955		Catholic Cemetery	

BUREAU V. 3

JUL 30 1956

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Date of Death		Date of Burial		Place of Burial	
Jan 20, 1955		Jan 25, 1955		Catholic Cemetery	
Signature of Registrar		Signature of Informant		Signature of Physician	
[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7189

CERTIFICATE OF DEATH

Reg. Dist. No. 131

07168

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 50 years				d. STREET ADDRESS 700 E. South Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jonathan Middle Claude Last Brightwell				4. DATE OF DEATH Month July Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15-1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 21 Days 19 Hours 56		IF UNDER 24 HRS. Months 21 Days 19 Hours 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder	
10b. KIND OF BUSINESS OR INDUSTRY Iron and Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Brightwell				14. MOTHER'S MAIDEN NAME Emma Stultz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-1561		17. INFORMANT Roger J. Brightwell- 700 E. South Street Frederick- Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Lung. 162X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Metastatic carcinoma liver DUE TO (c) Arterio-sclerosis (advanced)							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 22, 1956 , to July 21, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Professional Bldg.-Fred'k. Md.				DATE SIGNED July 23, 1956			
ACTUAL SIGNATURE B. O. Thomas Jr. M.D.							
PHYSICIAN'S NAME (Type) Dr. B.O. Thomas-Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son ADDRESS Frederick-Maryland				24a. REC'D BY REGISTRAR DATE 23 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hech	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07169

Reg. Dist. No.

131

7190

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
c. LENGTH OF STAY IN 1b 3 Days				d. STREET ADDRESS 736 North Market Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle E. Last BURRIER		4. DATE OF DEATH Month July Day 23 Year 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1865	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry O. Zimmerman				14. MOTHER'S MAIDEN NAME Martha Albaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edward R. Gearinger, 736 North Market St., Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, cerebral artery 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1956 to July 23, 1957 , that I last saw the deceased alive on July 23, 1956 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Stone				ADDRESS (Street, city or town, state) West Third Street, Frederick, Md. DATE SIGNED 7/24/56			
PHYSICIAN'S NAME (Type) Dr. Thomas E. Stone				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 26, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				40a. REC'D BY REGISTRAR 26 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
J. Edgar Hoover		Male		57		Jan 21, 1895		Washington, D.C.		Maryland		United States		United States	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S STATE		MOTHER'S STATE	
John Edgar Hoover		Annie Hoover		Lawyer		Homemaker		Maryland		Maryland		Maryland		Maryland	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE		WASHINGTON, D.C.	
Jan 27, 1956		Washington, D.C.		Heart Disease		Natural		100-374560		100-374560		100-374560		100-374560	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. A.

JUL 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7226

CERTIFICATE OF DEATH

Reg. Dist. No.

07179

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home				d. STREET ADDRESS 20 Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE VIRGINIA CASTLE				4. DATE OF DEATH Month Day Year July 2, 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 April 1866	
9. AGE (In years last birthday) yrs. 90		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Jacob N. Gibbons			
14. MOTHER'S MAIDEN NAME Mary Elizabeth (last name unknown)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Gilmer T. Castle, Sr. 212 S. Jefferson St., Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Fibrillation DUE TO Coronary Vascular Renal Disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 7 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1956 , to July 2, 1956 , that I last saw the deceased alive on July 2, 1956 , and that death occurred at 4 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. Lawrence Fahrney				M.D. 17 E. Second St., Frederick, Md. 7/3/56			
PHYSICIAN'S NAME (Type) H. Lawrence Fahrney, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5 July 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 5 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Hark			

BUREAU V. S.

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REGENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07160

Item 20 Film G201 8-3-56 ams

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick 7184 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 Week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 4268 Vacation Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last HARRIET JOHNSON ATWELL				4. DATE OF DEATH Month Day Year July 29, 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 31 May 1865	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME (First name unknown) Johnson				14. MOTHER'S MAIDEN NAME Mary Jane Livingston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Miss Ruth H. Atwell, Arlington, Virginia				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of right femur 903.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 1 week			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped on floor while going to front door of living room.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 11 7 18 1956				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Braddock Heights Fred. Md.				20g. (County) (State)			
21. I certify that I attended the deceased from 7/21 , 19 56 , to 7/29 , 19 56 , that I last saw the deceased alive on 7/29 , 19 56 , and that death occurred at 2:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. R. Schoolman				ADDRESS (Street, city or town, state) DATE SIGNED 228 N. Market St., Frederick, Md. 7/30/56			
PHYSICIAN'S NAME (Type) Louis R. Schoolman, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 30 July 1956		22c. NAME OF CEMETERY OR CREMATORY Zanesville, Ohio		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 30 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JULY 1, 1956	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTHPLACE		PLACE OF BIRTH	
Maryland		Maryland	
EDUCATION		OCCUPATION	
High School		Retired	
MARRIAGE		CAUSE OF DEATH	
Married		Heart Disease	
SPOUSE'S NAME		MANNER OF DEATH	
Mary H. Harris		Natural	
DATE OF MARRIAGE		PLACE OF DEATH	
June 15, 1920		Home	
PREVIOUS ILLNESS		SIGNATURE OF PHYSICIAN	
None		J. H. Harris	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
None		J. H. Harris, Mary H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE	
None		None	

BUREAU V. 2

AUG 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7185

CERTIFICATE OF DEATH

Reg. Dist. No.

97161

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 West South Street		d. STREET ADDRESS 300 West South Street	
3. NAME OF DECEASED (Type or print) First Harry Middle Vernon Last Bare		4. DATE OF DEATH Month July Day 3 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4-1882
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Bare		14. MOTHER'S MAIDEN NAME Anna E. McCormick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-0816	
17. INFORMANT Thomas Federline-300 W. South St-Frederick-Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Cardis Renal Vascular Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-16- , 19 54 , to 7-3 , 19 56 , that I last saw the deceased alive on 7-3 , 19 56 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 21.9 Bourne Jr M.D. 7-5-1956			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Dr. U.G. Bourne-Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-6-1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son - Frederick-Md.		24a. REC'D BY REGISTRAR DATE 6 July 1956	
24b. REGISTRAR'S SIGNATURE Eligible G Heck			

CERTIFICATE OF DEATH

DECEASED NAME John A. Jones		SEX Male		DATE OF BIRTH 1-1-1888		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Telephone Co.		MARITAL STATUS Married		PRESENT RESIDENCE 300 West Lombard Street		PLACE OF DEATH 300 West Lombard Street	
CAUSE OF DEATH (To be filled by physician)		MANNER OF DEATH (To be filled by physician)		TIME OF DEATH 10:15 AM		DATE OF DEATH July 8, 1956	
SIGNATURE OF PHYSICIAN (To be filled by physician)		SIGNATURE OF DECEASED (To be filled by deceased)		SIGNATURE OF WITNESSES (To be filled by witnesses)		SIGNATURE OF REGISTRAR (To be filled by registrar)	

BUREAU V. 8

JUL - 9 - 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the medical examiner. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7227

Reg. Dist. No. 131

07171

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 5 Frederick				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Clyde Middle Robert Last Caviness				4. DATE OF DEATH Month July Day 9 Year 19 56			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 12 1911		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months 5 Days 28	IF UNDER 24 HRS. Hours 28 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher-Van Lines		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Caviness				14. MOTHER'S MAIDEN NAME Cline McGee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Jan 32-Mar 53 219-34-5764		17. INFORMANT Thomas S. Glass		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poison 973.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE B.O. Thomas M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) B.O. THOMAS SR. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 July '56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE B. Bailey				ADDRESS 1201-N. Market Frederick		24a. REC'D BY REGISTRAR 10 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

DATE SIGNED
7/10/56

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John J. ...		Male		45		White		July 11, 1956		Home	
Residence		Occupation		Cause of Death		Manner of Death		Medical History		Remarks	
1234 ...		Carpenter		Heart Disease		Natural		Hypertension		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of ...		Signature of ...	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JUL 11 1956

RECEIVED

7228

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lime Kiln				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lime Kiln				d. STREET ADDRESS Lime Kiln			
3. NAME OF DECEASED (Type or print) Bertha First Middle Crompton Last				4. DATE OF DEATH July 14, 19 56 Month Day Year			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10-1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Canning Factory		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick-Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Posey				14. MOTHER'S MAIDEN NAME Charity Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Lena Bowman 1706 Artie Ave. Atlantic, City			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ch. Cardio Renal Vascular Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 3/4
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-6 , 19 54 , to 7-13 , 19 56 , that I last saw the deceased alive on 7-13 , 19 56 , and that death occurred at 1:AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30 West All Saints Street Fred. Md. DATE SIGNED 7-16-56							
ACTUAL SIGNATURE U. G. Bourne Jr. M.D.				PHYSICIAN'S NAME (Type) U. G. Bourne Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 18-56		22c. NAME OF CEMETERY OR CREMATORY Hope Hill		22d. LOCATION (City, town, or county) (State) Frederick-Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick Maryland				24a. REC'D BY REGISTRAR 17 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Hech	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MANNER OF DEATH [REDACTED]</p>		<p>10. PLACE OF DEATH [REDACTED]</p>	
<p>11. DATE OF DEATH [REDACTED]</p>		<p>12. TIME OF DEATH [REDACTED]</p>	
<p>13. SIGNATURE OF DECEASED [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>16. SIGNATURE OF CORONER [REDACTED]</p>	
<p>17. SIGNATURE OF JUDGE [REDACTED]</p>		<p>18. SIGNATURE OF CLERK [REDACTED]</p>	
<p>19. SIGNATURE OF [REDACTED]</p>		<p>20. SIGNATURE OF [REDACTED]</p>	
<p>21. SIGNATURE OF [REDACTED]</p>		<p>22. SIGNATURE OF [REDACTED]</p>	
<p>23. SIGNATURE OF [REDACTED]</p>		<p>24. SIGNATURE OF [REDACTED]</p>	
<p>25. SIGNATURE OF [REDACTED]</p>		<p>26. SIGNATURE OF [REDACTED]</p>	
<p>27. SIGNATURE OF [REDACTED]</p>		<p>28. SIGNATURE OF [REDACTED]</p>	
<p>29. SIGNATURE OF [REDACTED]</p>		<p>30. SIGNATURE OF [REDACTED]</p>	
<p>31. SIGNATURE OF [REDACTED]</p>		<p>32. SIGNATURE OF [REDACTED]</p>	
<p>33. SIGNATURE OF [REDACTED]</p>		<p>34. SIGNATURE OF [REDACTED]</p>	
<p>35. SIGNATURE OF [REDACTED]</p>		<p>36. SIGNATURE OF [REDACTED]</p>	
<p>37. SIGNATURE OF [REDACTED]</p>		<p>38. SIGNATURE OF [REDACTED]</p>	
<p>39. SIGNATURE OF [REDACTED]</p>		<p>40. SIGNATURE OF [REDACTED]</p>	
<p>41. SIGNATURE OF [REDACTED]</p>		<p>42. SIGNATURE OF [REDACTED]</p>	
<p>43. SIGNATURE OF [REDACTED]</p>		<p>44. SIGNATURE OF [REDACTED]</p>	
<p>45. SIGNATURE OF [REDACTED]</p>		<p>46. SIGNATURE OF [REDACTED]</p>	
<p>47. SIGNATURE OF [REDACTED]</p>		<p>48. SIGNATURE OF [REDACTED]</p>	
<p>49. SIGNATURE OF [REDACTED]</p>		<p>50. SIGNATURE OF [REDACTED]</p>	
<p>51. SIGNATURE OF [REDACTED]</p>		<p>52. SIGNATURE OF [REDACTED]</p>	
<p>53. SIGNATURE OF [REDACTED]</p>		<p>54. SIGNATURE OF [REDACTED]</p>	
<p>55. SIGNATURE OF [REDACTED]</p>		<p>56. SIGNATURE OF [REDACTED]</p>	
<p>57. SIGNATURE OF [REDACTED]</p>		<p>58. SIGNATURE OF [REDACTED]</p>	
<p>59. SIGNATURE OF [REDACTED]</p>		<p>60. SIGNATURE OF [REDACTED]</p>	
<p>61. SIGNATURE OF [REDACTED]</p>		<p>62. SIGNATURE OF [REDACTED]</p>	
<p>63. SIGNATURE OF [REDACTED]</p>		<p>64. SIGNATURE OF [REDACTED]</p>	
<p>65. SIGNATURE OF [REDACTED]</p>		<p>66. SIGNATURE OF [REDACTED]</p>	
<p>67. SIGNATURE OF [REDACTED]</p>		<p>68. SIGNATURE OF [REDACTED]</p>	
<p>69. SIGNATURE OF [REDACTED]</p>		<p>70. SIGNATURE OF [REDACTED]</p>	
<p>71. SIGNATURE OF [REDACTED]</p>		<p>72. SIGNATURE OF [REDACTED]</p>	
<p>73. SIGNATURE OF [REDACTED]</p>		<p>74. SIGNATURE OF [REDACTED]</p>	
<p>75. SIGNATURE OF [REDACTED]</p>		<p>76. SIGNATURE OF [REDACTED]</p>	
<p>77. SIGNATURE OF [REDACTED]</p>		<p>78. SIGNATURE OF [REDACTED]</p>	
<p>79. SIGNATURE OF [REDACTED]</p>		<p>80. SIGNATURE OF [REDACTED]</p>	
<p>81. SIGNATURE OF [REDACTED]</p>		<p>82. SIGNATURE OF [REDACTED]</p>	
<p>83. SIGNATURE OF [REDACTED]</p>		<p>84. SIGNATURE OF [REDACTED]</p>	
<p>85. SIGNATURE OF [REDACTED]</p>		<p>86. SIGNATURE OF [REDACTED]</p>	
<p>87. SIGNATURE OF [REDACTED]</p>		<p>88. SIGNATURE OF [REDACTED]</p>	
<p>89. SIGNATURE OF [REDACTED]</p>		<p>90. SIGNATURE OF [REDACTED]</p>	
<p>91. SIGNATURE OF [REDACTED]</p>		<p>92. SIGNATURE OF [REDACTED]</p>	
<p>93. SIGNATURE OF [REDACTED]</p>		<p>94. SIGNATURE OF [REDACTED]</p>	
<p>95. SIGNATURE OF [REDACTED]</p>		<p>96. SIGNATURE OF [REDACTED]</p>	
<p>97. SIGNATURE OF [REDACTED]</p>		<p>98. SIGNATURE OF [REDACTED]</p>	
<p>99. SIGNATURE OF [REDACTED]</p>		<p>100. SIGNATURE OF [REDACTED]</p>	

BUREAU V. 1

JUL 18 1956

RECEIVED

7229

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cullen	LENGTH OF STAY (in this place) 3399 days	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 925 S. Fremont Street	
3. NAME OF DECEASED: (First) Harry (Middle) (Last) Cubitt		4. DATE (Month) (Day) (Year) OF DEATH: 7 2 19 56	
5. SEX: M	6. COLOR OR RACE: W	7. STATUS Divorced	8. DATE OF BIRTH: 9/18/1903
9. AGE last birthday 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10B. KIND OF BUSINESS OR INDUSTRY: Hospital orderly	
11. BIRTHPLACE (State or foreign country): Ontario, Canada		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Frederick Cubitt		14. MOTHER'S MAIDEN NAME: Mabel Reid	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: 217-18-5729	
17. INFORMANT & ADDRESS: Mr. Harry Cubitt 925 S. Fremont St., Baltimore, Maryland.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary tuberculosis			10 yrs.
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/13/1946 , to 7/2/1956 , that I last saw the deceased alive on 7/2/1956 , and that death occurred at 8:25 AM , from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS Cullen, Maryland. DATE SIGNED 7/2/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Petersborough, Ont., Canada			
DATE REC'D BY LOCAL REGISTRAR 7/2/56		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR		ADDRESS	
M.L. Creager & Son, Thurmont, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07174

7191

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 2-Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 109 West 14th Street			
3. NAME OF DECEASED (Type or print) First ALBERT Middle FRANKLIN Last CULLER				4. DATE OF DEATH Month July Day 30 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1887	
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Culler				14. MOTHER'S MAIDEN NAME Annie E. Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-14-5418		17. INFORMANT Mrs. Edward L. Pease, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial infarction (ant.) 1957				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 6 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 July 1956 , to 30 July 1956 , that I last saw the deceased alive on 30 July 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles H. Conley, Jr.				ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 8/1/56			
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 2, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 2 Aug 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

251

BUREAU V. S.

AUG 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07175

7230

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown,			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Adamstown				d. STREET ADDRESS Near Adamstown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle MAY Last CUTSAIL				4. DATE OF DEATH Month July Day 19 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1891		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 6 Days 19	IF UNDER 24 HRS. Hours 19 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Baker				14. MOTHER'S MAIDEN NAME Emma E. Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lewis M. Cutsail, Adamstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma left lung 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 wks.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Feb , 19 56 , to July 19 , 19 56 , that I last saw the deceased alive on July 18 , 19 56 , and that death occurred at 12:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church St., Frederick, Md. DATE SIGNED 7/20/1956 ACTUAL SIGNATURE R. E. Martin M.D. PHYSICIAN'S NAME (Type) Dr. Rex R. Martin East Church St., Frederick, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 20 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heath	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Place of Report		Remarks	

BUREAU V. S.

JUL 23 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7192

CERTIFICATE OF DEATH

07176

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HARRY Last DUBLE		4. DATE OF DEATH Month July Day 24 , Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 21, 1889 66
9. AGE (In years lost birthday) yrs. 66		10. IF UNDER 1 YEAR Months 24 Days 19 Hours 56	11. IF UNDER 74 HRS. Months 24 Days 19 Hours 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auto Salesman		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hesikiah Duble		14. MOTHER'S MAIDEN NAME Isabell Duble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW1		16. SOCIAL SECURITY NO. WW1	
17. INFORMANT Miss Katharine Lease, Frederick, Maryland		Address 231 North Market Street,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - (Myocardial) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Coronary Embolus		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1 - 1951 , to July 24, 1956 , that I last saw the deceased alive on July 24, 1956 , and that death occurred at 12:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. L. Fahrney		M.D. East Second Street, Frederick, Md. 7/24/1956	
PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney		Address East Second Street, Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1956	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DATE 26 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Hersh	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home		Signature of Cemetery		Signature of Burial Place		Signature of Burial Date		Signature of Burial Time		Signature of Burial Place		Signature of Burial Date		Signature of Burial Time	
John Doe		Male		45		1910		Maryland		Baltimore		Heart Disease		July 27		10:00 AM		Home		Natural		Dr. J. Smith		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe					

BUREAU V. S.

JUL 27 1956

RECEIVED

CERTIFICATE OF DEATH

7193

07137

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jacob Middle Melvin Last Dusing				4. DATE OF DEATH Month 7 Day 3 Year 19 56			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1872		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner				10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Jacob Dusing				14. MOTHER'S MAIDEN NAME Malinda Morrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Gladys Adams, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of lung with metastasis to brain DUE TO 163 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) unknown DUE TO (c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11/55 , 19 55 , to 7/3 , 19 56 , that I last saw the deceased alive on 7/3 , 19 56 , and that death occurred at 1:00 P. M, from the causes and on the date stated above. ADDRESS (street, city or town, state) Middletown DATE SIGNED 7/5/56							
ACTUAL SIGNATURE Kenneth C. Henson M.D.							
PHYSICIAN'S NAME (Type) Dr. Kenneth C. Henson				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/1956		22c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery		22d. LOCATION (City, town, or county) (State) Myersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE 6 July 1956	
						24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Form 10-54

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>NEW YORK</i>		5. DATE OF BIRTH <i>1910</i>		6. PLACE OF DEATH <i>Baltimore, Md.</i>	
7. OCCUPATION <i>Engineer</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. DATE OF DEATH <i>July 5, 1956</i>		11. TIME OF DEATH <i>10:15 AM</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>	
16. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		17. SIGNATURE OF CLERK <i>[Signature]</i>		18. SIGNATURE OF CHURCH CLERK <i>[Signature]</i>	
19. SIGNATURE OF BURIAL CLERK <i>[Signature]</i>		20. SIGNATURE OF FUNERAL HOME <i>[Signature]</i>		21. SIGNATURE OF CEMETERY <i>[Signature]</i>	
22. SIGNATURE OF STATE DEPARTMENT OF HEALTH <i>[Signature]</i>		23. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH <i>[Signature]</i>		24. SIGNATURE OF CITY DEPARTMENT OF HEALTH <i>[Signature]</i>	
25. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH <i>[Signature]</i>		26. SIGNATURE OF LOCAL DEPARTMENT OF HEALTH <i>[Signature]</i>		27. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
28. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		29. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		30. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
31. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		32. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		33. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
34. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		35. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		36. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
37. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		38. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		39. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
40. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		41. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		42. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
43. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		44. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		45. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
46. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		47. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		48. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
49. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		50. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		51. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
52. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		53. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		54. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
55. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		56. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		57. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
58. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		59. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		60. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
61. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		62. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		63. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
64. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		65. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		66. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
67. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		68. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		69. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
70. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		71. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		72. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
73. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		74. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		75. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
76. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		77. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		78. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
79. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		80. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		81. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
82. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		83. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		84. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
85. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		86. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		87. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
88. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		89. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		90. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
91. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		92. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		93. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
94. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		95. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		96. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
97. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		98. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		99. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	
100. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		101. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		102. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>	

RECEIVED
JUL 9 1956
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07178

Reg. Dist. No. 131

7231

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Myersville</u> c. LENGTH OF STAY IN 1b <u>one month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Myersville</u> d. STREET ADDRESS <u>Route # 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Glen</u> First <u>Early</u> Middle Last 4. DATE OF DEATH <u>July</u> Month <u>1</u> Day <u>19</u> Year <u>52</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 17, 1900</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. AGE (In years last birthday) <u>55</u> yrs. FUNDER 1 YEAR <u>55</u> Months <u>1</u> Days <u>1</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farm</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>William Early</u> 14. MOTHER'S MAIDEN NAME <u>Cordeia Holmes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. <u>217-16-2104</u> 17. INFORMANT <u>Mrs Virginia Boyer</u> Address <u>Rt. # 1 Frederick, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>19</u> o. m. <u>19</u> p. m. 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>B. O. Thomas</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>July 1-1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>July 4, 1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Grossnickle's</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u> ADDRESS <u>Myersville, Md.</u>		22d. LOCATION (City, town, or county) <u>Nr. Myersville, Fred. Co. Md.</u> (State) _____ 24a. REC'D BY REGISTRAR <u>Elizabeth S. Hach</u> 24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Hach</u> DATE <u>3 July 1956</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 5 1956

BUREAU V. 3

7232

CERTIFICATE OF DEATH

Reg. Dist. No. 140

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodsboro</u>			
c. LENGTH OF STAY IN b. <u>40 yrs.</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE LEWIS ETZLER</u>				4. DATE OF DEATH Month Day Year <u>July 7 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 13 1889</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher Elementary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Jeremiah Etzler</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Martz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-34-1084</u>			
17. INFORMANT <u>Mrs. Alice V. Etzler</u>				Address <u>Woodsboro Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>10 years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>7 July, 1956</u> , to <u>July, 1956</u> that I last saw the deceased alive on <u>7 July, 1956</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Walbersville, Md.</u> DATE SIGNED <u>7 July 1956</u>			
PHYSICIAN'S NAME (Type) <u>James E. Stoner Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Woodsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Payvelly Hartzler</u> ADDRESS <u>Woodsboro, Md.</u>				24a. REC'D BY REGISTRAR <u>July 10</u>		24b. REGISTRAR'S SIGNATURE <u>L B Powell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

Reg. Dist. No.

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to fading and bleed-through.

BUREAU V. 3

UL 12 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07180

7220

CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Floyd Middle Edward Last Forrest		4. DATE OF DEATH Month 7 Day 20 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1900
9. AGE (In years last birthday) yrs. 56		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Mail		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R. Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edwin Sheridan Forrest		14. MOTHER'S MAIDEN NAME Etta Jennings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-8058	
17. INFORMANT Mrs. Bessie Forrest		Address Brunswick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Cardiac asthma over many years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 3, 1956 to July 20, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at 5:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. M. Thomason M.D. 115 E. Potomac St., Brunswick, Md.			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-1956	
22c. NAME OF CEMETERY OR CREMATORY Locust Valley		22d. LOCATION (City, town, or county) (State) (Rural) Burkittsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. L. Felt		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR JUL 26 1956		24b. REGISTRAR'S SIGNATURE Eugenia Burkey	

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BUREAU V. 3

JUL 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7194

CERTIFICATE OF DEATH

Reg. Dist. No. 07181 131

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 6wk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hosp				d. STREET ADDRESS RFD 5			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Richard Middle Allen Last Fulmer				4. DATE OF DEATH Month July Day 4 Year 1956			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 May 56	
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 19		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George William Fulmer				14. MOTHER'S MAIDEN NAME Mary Gladys Blank			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Father Address RFD 5, Frederick	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA, STAPHYLOCOCCAL 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1 July , 19 56 , to 4 July , 19 56 that I last saw the deceased alive on 4 July , 19 56 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 North Market St., Frederick, Md. DATE SIGNED 7/5/1956 ACTUAL SIGNATURE Fred G. Heldrich PHYSICIAN'S NAME (Type) Fred G. Heldrich Same as above							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 5 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		DRIVER		HEART DISEASE		SUICIDE	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
JAN 6 1968		MOBILE		ALABAMA		UNITED STATES		UNITED STATES		JAN 10 1968		MOBILE		ALABAMA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

JUL 6 1956

RECEIVED

7233 CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cullen	LENGTH OF STAY (in this place) 7101 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 2009 E. Monument Street	
3. NAME OF DECEASED: (First) Albert (Middle) Philip (Last) Gollery		4. DATE (Month) (Day) (Year) OF DEATH: 7 3 19 56	
5. SEX: M	6. COLOR OR RACE:	7. SINGLE MARRIED (Specify) Married	8. DATE OF BIRTH: 8/23/1899
9. AGE last birthday 56 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman		10B. KIND OF BUSINESS OR INDUSTRY: Foreman	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Thomas J. Gollery	
14. MOTHER'S MAIDEN NAME: Catherine McDermott		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mr. Albert P. Gollery 2009 E. Monument St., Balto., Maryland.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Pulmonary tuberculosis			21 years
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/23/ 19 37 , to 7/3/ 19 56 , that I last saw the deceased alive on 7/3/ 19 56 , and that death occurred at 3:00 A M, from the causes and on the date stated above.			
SIGNATURE [Signature]		M. D. Cullen, Maryland DATE SIGNED 7/3/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-6-56	
NAME OF CEMETERY OR CREMATORY Moreland Mem.		LOCATION (City, town, or county) (State) Balto. Co., Md.	
DATE REC'D BY LOCAL REGISTRAR 7/3/56		REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR		ADDRESS Tickner & Sons, North & Pa. Aves. Balto.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07183

7195

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Ann</u> Last <u>Gosnell</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>w</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 24, 1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>14</u> Min.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Caleb Cross</u>			
14. MOTHER'S MAIDEN NAME <u>? - Brashers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mr Basil W. Gosnell - Mt Airy, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420.0 DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>104r5t</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7/6</u> , 19 <u>56</u> , to <u>7/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>56</u> , and that death occurred at <u>7:40 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u>				ADDRESS (Street, city or town, state) <u>4 E. Church St</u>			
PHYSICIAN'S NAME (Type) <u>Henry V Chase</u>				DATE SIGNED <u>7/9/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect</u>	
22d. LOCATION (City, town, or county) <u>Mt Airy, Md.</u>				22e. (State) <u>Md.</u>		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Walz</u>				ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE				DATE		24c. (County)	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAKALAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7-10-68

BUREAU V. S.

JUL 13 1956

RECEIVED

7196

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL HOSP.</u>				d. STREET ADDRESS <u>FREDERICK MIDDLETOWN RD 21</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER THOMAS HAMMOND</u>				4. DATE OF DEATH Month Day Year <u>7 1 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-56</u>	9. AGE (In years last birthday) yrs. <u>11</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES T. HAMMOND</u>				14. MOTHER'S MAIDEN NAME <u>ESTELLE KETTERMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Route 2</u> <u>Chas. T. Hammond - Middletown - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IRREVERSIBLE SHOCK</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>GANGRENE OF INTESTINES</u> DUE TO (c) <u>MESENTERIC THROMBOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-26</u> , 19 <u>56</u> , to <u>7-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>220 N. MARKET ST. 7-1-56</u>							
ACTUAL SIGNATURE <u>Fred J. Heldrich Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>FREDERICK, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK - MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son</u> ADDRESS <u>Frederick - Md.</u>				24a. REC'D BY REGISTRAR DATE <u>2 July 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07185

CERTIFICATE OF DEATH

Reg. Dist. No.

141

7221

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 West "I"		d. STREET ADDRESS 24 West "I"	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Columbus Hardy		4. DATE OF DEATH Month Day Year 7 25 19 56	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1866
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Teamster	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hardy		14. MOTHER'S MAIDEN NAME Caroline Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Bettie Hardy		Address Brunswick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Cardiac Failure DUE TO (b) Arterio Sclerosis DUE TO (c) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12, 1956, to 7/25, 1956, that I last saw the deceased alive on 12, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. M. Thompson		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-1956	
22c. NAME OF CEMETERY OR CREMATORY A.M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Petersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Brunswick, Maryland	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

191

DEPARTMENT OF HEALTH - BALTIMORE, MD. COUNTY OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH - BALTIMORE, MD. COUNTY OF BALTIMORE CITY OF BALTIMORE	
NAME OF DECEASED Joseph Henry		NAME OF DECEASED Joseph Henry	
SEX Male		SEX Male	
AGE 37		AGE 37	
DATE OF BIRTH 1919		DATE OF BIRTH 1919	
PLACE OF BIRTH Baltimore, Md.		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Clerk		OCCUPATION Clerk	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH Home		PLACE OF DEATH Home	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DEATH REGISTRAR [Signature]		SIGNATURE OF DEATH REGISTRAR [Signature]	
DATE OF DEATH July 30, 1956		DATE OF DEATH July 30, 1956	

BUREAU V. S.

JUL 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07186

Reg. Dist. No. 144

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> 7234 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croagstown</u> c. LENGTH OF STAY IN 1b <u>67 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croagstown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Ruth</u> Last <u>Hanner</u>			4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1888</u>		9. AGE (In years last birthday) <u>67</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Fredrick Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>A. Scott Long</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ellen Favorite</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Mabel Whitmore Thompson</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by Hanging</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B. O. Thomas</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>July 28, 1956</u>		
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>A. H. Hanch</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 1-1956</u>		22b. DATE THEREOF <u>Aug 1-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Croagstown Cem. Croagstown</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond Croag</u>		ADDRESS <u>Thurmont Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 8-1-56</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF ILLINOIS
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "August 1, 1956"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
SIGNATURE OF MEDICAL EXAMINER [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	

BUREAU V. S.

AUG 1 1956

RECEIVED

7197

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Mt. Airy</i>			
c. LENGTH OF STAY IN 1b <i>2 days</i>				d. STREET ADDRESS <i>Mt. Olive</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs. Effie Lee Henry</i>				4. DATE OF DEATH <i>July 11 1956</i>			
5. SEX <i>F.</i>		6. COLOR OR RACE <i>W.</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 22 1882</i>	
9. AGE (In years last birthday) <i>74</i> yrs		IF UNDER 1 YEAR Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.		IF UNDER 24 HRS. Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
11. BIRTHPLACE (State or foreign country) <i>Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>William Fleming</i>				14. MOTHER'S MAIDEN NAME <i>Emma Harver</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>none</i>			
17. INFORMANT <i>Mrs. Corline Henry - Mt. Airy, Md.</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i> (c) <i>Arteriosclerotic Coronary</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <i>July 9 1956</i> to <i>July 11 1956</i> , that I last saw the deceased alive on <i>July 11 1956</i> , and that death occurred at <i>9:50 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Frederick, Md.</i> DATE SIGNED <i>7/11/56</i>							
ACTUAL SIGNATURE <i>A. A. Pearre</i> M.D.							
PHYSICIAN'S NAME (Type) <i>A. A. PEARRE</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>7-15-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cheney</i>	
22d. LOCATION (City, town, or county) <i>Winfield, Md.</i>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. M. Walz</i>				ADDRESS <i>Winfield, Md.</i>		24a. REC'D BY REGISTRAR <i>July 16 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>Ely G. Beck</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

16 JUL 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7235

CERTIFICATE OF DEATH

Reg. Dist. No. 07188 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeystown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First NORMAN Middle CULLISON Last HILTON				4. DATE OF DEATH Month July Day 17 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1891		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Farmers Co-op		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James R. Hilton				14. MOTHER'S MAIDEN NAME Florence L. Becraft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2599		17. INFORMANT Mrs. Gilbert B. Simmers, Port Deposit, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy involving liver 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spine & lungs, most probably DUE TO (c) originating in large bowel							INTERVAL BETWEEN ONSET AND DEATH Jan. 1956 (7 mos)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic heart dis. with Angina							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1956 to 7/17 , 19 56 , that I last saw the deceased alive on 16 July , 19 56 , and that death occurred at 5:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 7/18/56							
ACTUAL SIGNATURE Charles H. Conley, Jr.			M.D. Professional Bldg., Frederick, Md.				
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley, Jr.			Same as Above				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1956		22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel Cem.		22d. LOCATION (City, town, or county) (State) Montgomery County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR 20 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Hester			

BUREAU V. 8

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7198

CERTIFICATE OF DEATH

Reg. Dist. No. 07189131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gardenville	
c. LENGTH OF STAY IN b. Since 2/16/51		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION I. O. O. F. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle CATHERINE Last HOFSTETTER		4. DATE OF DEATH Month July Day 12 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Dec 1864
9. AGE (In years last birthday) yrs. 91		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence Hofstetter		14. MOTHER'S MAIDEN NAME Catherine Lutz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT I. O. O. F. Home Records (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 56 , to July 12 , 19 56 , that I last saw the deceased alive on July 12 , 19 56 , and that death occurred at 8 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4 E. Church St., Frederick, Md. 7/13/56			
ACTUAL SIGNATURE E. P. Thomas M.D.			
PHYSICIAN'S NAME (Type) E. P. Thomas, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 July 1956	
22c. NAME OF CEMETERY OR CREMATORY Jerusalem Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Baltimore County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR 13 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15, 1956</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Immediate cause: <u>Myocardial Infarction</u></p>		<p>8. Underlying cause: <u>Coronary Atherosclerosis</u></p>	
<p>9. Contributing cause: <u>None</u></p>		<p>10. Manner of death: <u>Natural</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>Jan 16, 1956</u></p>		<p>14. Office of registration: <u>Baltimore</u></p>	

BUREAU V. 3

JUL 16 1956

RECEIVED

7236

CERTIFICATE OF DEATH

Reg. Dist. No. 145

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Myersville				c. LENGTH OF STAY IN 1b 32 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Route # 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle MARIE Last HOOVER				4. DATE OF DEATH Month July Day 26 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1883	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Smith				14. MOTHER'S MAIDEN NAME Frances Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-22-7724		17. INFORMANT C.C. Hoover, Jr. Address Myersville, Md. Rt. #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1956 , to July 26, 1956 , that I last saw the deceased alive on July 26, 1956 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Elmer Harp M.D.				ADDRESS (Street, city or town, state) Middletown DATE SIGNED 7-27-56			
PHYSICIAN'S NAME (Type) J. Elmer Harp				Middletown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1956		22c. NAME OF CEMETERY OR CREMATORY Grossnickle's		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle ADDRESS Myersville, Md.				24a. REC'D BY REGISTRAR 7-29-1956		24b. REGISTRAR'S SIGNATURE Paul F. Bittle	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1956 31 JUL

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7199
CERTIFICATE OF DEATH

Reg. Dist. No. 131

07191
131

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-- Rt. # 3, FREDERICK		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		d. STREET ADDRESS FREDERICK, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND L. KEMP		4. DATE OF DEATH Month Day Year JULY 5, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June, 23, 1895
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 12	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY PAINTER	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME LOUIS C. KEMP.		14. MOTHER'S MAIDEN NAME JEANETTA GROVE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-20-2741	
17. INFORMANT WIFE, Mrs. Elanor M. Kemp.		Address Rt. # 3, Frederick	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lower rt lobe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2			INTERVAL BETWEEN ONSET AND DEATH 2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 3, 1956 , to July 5, 1956 that I last saw the deceased alive on July 4, 1956 , and that death occurred at 6:12 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED B. O. Thomas M.D. 228 N Market Frederick, Md 7/6/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 7, 1956	22c. NAME OF CEMETERY OR CREMATORY ROCKY SPRINGS CEMETERY
23. FUNERAL DIRECTOR'S SIGNATURE Elizabeth H. Heck		24. REC'D BY REGISTRAR DATE 9 July 1956	
24b. REGISTRAR'S SIGNATURE Elizabeth H. Heck		24c. LOCATION (City, town, or county) (State) FREDERICK, MARYLAND	

7200

CERTIFICATE OF DEATH

Reg. Dist. No. 131

07192

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maude Belle King		4. DATE OF DEATH July 5 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH Sept. 1-1890
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis E. Crouse		14. MOTHER'S MAIDEN NAME Fannie E. Wilhide	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Irvin F. Crouse- Frederick- R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO (b) Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fracture of hip 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from June 25 , 19 54 , to July 5 , 19 56 , that I last saw the deceased alive on July 5 , 19 56 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 E. 2nd. St- Frederick-Md. DATE SIGNED 7-6-56 ACTUAL SIGNATURE H. L. Fahrney M.D. PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 9-1956	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cheney & Son - Frederick, Md. ADDRESS		24a. REC'D BY REGISTRAR 9 July 1956 24b. REGISTRAR'S SIGNATURE Elizabeth B. Hersh	

7201

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS 25 E. Patrick Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elsie Middle Virginia Last Lambert				4. DATE OF DEATH Month July Day 14 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Apr. 29-1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Carlisle				14. MOTHER'S MAIDEN NAME Frances Appleby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-32-5664		17. INFORMANT Mrs. Harry D. Shildt-25 E. Patrick St.- Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 250.1 (b) Coronary Sclerosis DUE TO (c) Diabetes mellitus, Essential hyper tension				INTERVAL BETWEEN ONSET AND DEATH 24 hours 7 years +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 14, 1954 , to July 14, 1956 , that I last saw the deceased alive on July 14, 1956 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. R. Schoolman				ADDRESS (Street, city or town, state) Professional Bldg.-Frederick-Md. DATE SIGNED 7/16/56			
PHYSICIAN'S NAME (Type) Dr. L.R.Schoolman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-18-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son - W.				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR 17 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Hark			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 18 1956

BUREAU V. S.

7237

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, Md.			
c. LENGTH OF STAY IN 1b 65 yrs.				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Long Last Long				4. DATE OF DEATH Month July. Day 5, Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May. 31, 1873	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months 1 Days 4 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Hardware				10b. KIND OF BUSINESS OR INDUSTRY Own Store		11. BIRTHPLACE (State or foreign country) Rocky Ridge, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Abraham Long				14. MOTHER'S MAIDEN NAME Amanda Menges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-26-1350		17. INFORMANT Address Mrs. Margaret Creeger--Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease arteriosclerotic type 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, rheumatism, old age DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs 5 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Thurmont, Md.				20g. (County) Frederick		20h. (State) Md.	
21. I certify that I attended the deceased from May 1 - 1956 to July 4 - 1956 , that I last saw the deceased alive on July 4 - 1956 , and that death occurred at 3:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED James K. Gray							
ACTUAL SIGNATURE James K. Gray				PHYSICIAN'S NAME (Type) Thurmont - Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July. 7, 1956		22c. NAME OF CEMETERY OR CREMATORY Blue Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Thurmont, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Creeger				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR JUL 9 1956	
24b. REGISTRAR'S SIGNATURE d. H. Hedrick							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.
RECEIVED
JUL 9 1956

July 12, 1956
Bureau of Health Statistics
Bureau of Vital Statistics

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07195

7202

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 526 22nd Street N. W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First NARCIE Middle ALICE Last MARRIOTTE				4. DATE OF DEATH Month July Day 22 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 20, 1873	
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles W. Marriotte		14. MOTHER'S MAIDEN NAME Susan Anna Elizabeth Friday			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Louella M. Hesson, 23 West Patrick Street, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leukemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 July, 1956 to 22 July, 1956 , that I last saw the deceased alive on 22 July, 1956 , and that death occurred at 3:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 7/24/56							
ACTUAL SIGNATURE Charles H. Conley Jr.		M.D. Professional Bldg., Frederick, Md.					
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley Jr.		Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25, 1956		22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Jefferson, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS Frederick, Maryland		24a. REC'D BY REGISTRAR DATE 25 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck			

7293

CERTIFICATE OF DEATH

07196

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 1 Hour			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle IRENE Last MASSER				4. DATE OF DEATH Month July Day 12 Year 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1898	
9. AGE (In years last birthday) yrs. 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Conrad Schultz			
14. MOTHER'S MAIDEN NAME Mary Ellen Blank				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO.				17. INFORMANT Address Mrs. John L. Hahn, Frederick, R. D. #6, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. Hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7-12-1956 to 7-12-1956 , that I last saw the deceased alive on 7-12-1956 , and that death occurred at 8:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rex R. Martin M.D.				ADDRESS (Street, city or town, state) DATE SIGNED East Church Street, Frederick, Md. 7/14/1956			
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin				Same As Above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1956		22c. NAME OF CEMETERY OR CREMATORY Rocky Springs Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 16 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth S. Heck	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John A. Smith		Male		45		Jan 1, 1910		Boston, Mass.		Boston, Mass.		Heart Disease		July 15, 1956		10:00 AM		St. John's Hospital		Dr. J. H. Smith		J. H. Smith	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice		Last Medical Treatment	
Teacher		Married		None		June 1, 1956		June 1, 1956		June 1, 1956		June 1, 1956		June 1, 1956		June 1, 1956		June 1, 1956		June 1, 1956		June 1, 1956	
Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician		Signature of Registrar		Signature of Physician	
St. John's Hospital		July 15, 1956		10:00 AM		Dr. J. H. Smith		J. H. Smith		Dr. J. H. Smith		J. H. Smith		Dr. J. H. Smith		J. H. Smith		Dr. J. H. Smith		J. H. Smith		Dr. J. H. Smith	

RECEIVED
JUL 18 1956
BUREAU V. A.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN b. Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent Home		d. STREET ADDRESS 731 North Market Street	
3. NAME OF DECEASED (Type or print) First JOHN Middle MARSHALL Last MILLER		4. DATE OF DEATH Month July Day 13 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1857
9. AGE (In years last birthday) 98 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Vice President		10b. KIND OF BUSINESS OR INDUSTRY Bank	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George W. Miller		14. MOTHER'S MAIDEN NAME Caroline Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Naomi M. Koefoed,		11 Millside Avenue, Towson 4, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Renal Disease (c) Senility			INTERVAL BETWEEN ONSET AND DEATH 1 day 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 28 , 19 56 , to July 13 , 19 56 , that I last saw the deceased alive on July 13 , 19 56 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Second Street, Frederick, Md. DATE SIGNED 7/14/56			
ACTUAL SIGNATURE H. L. Fahrney		M.D. East Second Street, Frederick, Md. 7/14/56	
PHYSICIAN'S NAME (Type) Dr. H. L. Fahrney		Same as Above	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR 16 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Decker	

CERTIFICATE OF DEATH

1933

131

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
George		Male		45		1888		Maryland		Baltimore		Heart Disease		Baltimore		10:30 PM		J. H. Smith		J. H. Smith	
Occupation		Race		Color		Marital Status		Education		Religion		Previous Illnesses		Alcohol		Tobacco		Drugs		Other	
None		White		White		Married		High School		Catholic		None		None		None		None		None	
Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Report		Place of Report		Time of Report		Signature of Physician		Signature of Registrar		Date of Report	
1933		Baltimore		10:30 PM		J. H. Smith		J. H. Smith		1933		Baltimore		10:30 PM		J. H. Smith		J. H. Smith		1933	

BUREAU V. 3

47-18-1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07198

Reg. Dist. No. 134

7204

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 				d. STREET ADDRESS <u>32 E. Fourth St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Johnson Miss</u>				4. DATE OF DEATH Month Day Year <u>July 15 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 August 1930</u>	
9. AGE (In years last birthday) <u>25</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Grayson Martin MISS</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lee JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Washington, D.C.</u> <u>(Wife) Mrs. Evelyn May MISS, 1219 Alabama Ave., NE,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>974X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </div> <div style="width: 60%;"> Strangulation by hanging DUE TO (b) DUE TO (c) </div> <div style="width: 10%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>B.O. Thomas</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>B.O. Thomas</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>July 16, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. PUMPHREY</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>July 19, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Ely. G. Seely</u>				24c. REGISTRAR'S NAME <u>Ely. G. Seely</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. Prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 19 1956

RECEIVED

7205

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY <u>FREDERICK</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>FREDERICK</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FREDERICK</u>			
c. LENGTH OF STAY IN 1b <u>7 hrs.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FREDERICK MEMORIAL</u>				d. STREET ADDRESS <u>408 COLUMBUS AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOEL</u> Middle <u>CURTIS</u> Last <u>MOORE II</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-56</u>		9. AGE (In years last birthday) yrs. <u>7</u>	10. IF UNDER 1 YEAR Months <u>7</u> Days <u>33</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>JOEL CURTIS MOORE</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE GERTRUDE WEESE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY IMMATUREITY</u> <u>774x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-11-1956</u> , to <u>7-11-1956</u> , that I last saw the deceased alive on <u>7-11-1956</u> , and that death occurred at <u>3:52 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Fred J. Heldrich</u> M.D.				PHYSICIAN'S NAME (Type) <u>FRED J. HELDRICH 220 N. MARKET ST. (FRED, MD.)</u>			
22a. BURIAL-CREATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7/12/56</u>		<u>Mt. Olivet Cemetery</u>		<u>FREDERICK, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elizabeth S. Heck</u>				24a. REC'D BY REGISTRAR DATE <u>12 July 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth S. Heck</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

7206

CERTIFICATE OF DEATH

07200

Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Loudoun			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN TB 6 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Lovettsville			
3. NAME OF DECEASED (Type or print) First PAUL Middle WINFIELD Last MYERS				4. DATE OF DEATH Month July Day 9 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 14 Oct 1880	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Car Repairman				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME George W. Myers				14. MOTHER'S MAIDEN NAME Sarah Havener			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-2894		17. INFORMANT Mrs. Winnie Myers, Lovettsville, Virginia			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 40 days 6 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis Heart Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Lovettsville, Virginia				20g. (County) Loudoun		20h. (State) Virginia	
21. I certify that I attended the deceased from 5/28 , 19 56 , to 7/9 , 19 56 , that I last saw the deceased alive on 7/8 , 19 56 , and that death occurred at 12:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St., Frederick, Md. DATE SIGNED 7/9/56 ACTUAL SIGNATURE Henry V Chase M.D. PHYSICIAN'S NAME (Type) Henry V. Chase, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 July 1956		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery		22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 9 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

Wm. T. Jordan

U. S. National Academy of Sciences

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7207

CERTIFICATE OF DEATH

67201

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			c. LENGTH OF STAY IN 1b 52 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ALICE Middle THOMSON Last NEWMAN			4. DATE OF DEATH Month July Day 1 Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1880		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Thomson			14. MOTHER'S MAIDEN NAME Elizabeth Stanfield		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Parsons Newman Address 303 Upper College Terrace, Frederick, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Hypertension					INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick		(County) (State)
21. I certify that I attended the deceased from Dec 31 , 19 55 , to July 1 , 19 56 , that I last saw the deceased alive on July 1 , 19 56 , and that death occurred at 3:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) East Church St., Frederick, Md. DATE SIGNED 7/2/1956 ACTUAL SIGNATURE A. A. Pearre M.D. PHYSICIAN'S NAME (Type) Dr. A. A. Pearre East Church St., Frederick, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 3, 1956	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR 2 July 1956	24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7239

CERTIFICATE OF DEATH

Reg. Dist. No.

07202 131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick - Rural				c. LENGTH OF STAY IN 1b 2 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital				d. STREET ADDRESS Reels Mills			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last O'BRIEN				4. DATE OF DEATH Month July Day 12 , Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1874		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Josiah Stup				14. MOTHER'S MAIDEN NAME Annie Catherine Angleberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nonn		17. INFORMANT Mr. Russell E. O'Brien, Frederick, R.D.#2, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH None
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , to 7/12, 1956 , that I last saw the deceased alive on June 1956 , and that death occurred at 2:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg., Frederick, Md. DATE SIGNED 7/14/1956							
ACTUAL SIGNATURE James B. Thomas				M.D. Professional Bldg., Frederick, Md.			
PHYSICIAN'S NAME (Type) Dr. James B. Thomas				Same AS Above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 14 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

7208

07203

Reg. Dist. No. 131

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Frederick</u>		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		LENGTH OF STAY (In this place) <u>2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>			
TOWN <u>Frederick</u>				TOWN <u>Frederick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>703 Rosemont Ave</u>				STREET ADDRESS (If rural give location) <u>703 Rosemont Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Osage</u> (Last) <u>Poplo</u>				(Month) <u>July</u> (Day) <u>31</u> (Year) <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Unknown</u>	
				9. AGE last birthday <u>80</u> yrs.		10. IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u> IF UNDER 24 HRS. (Hours) <u></u> (Min.) <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Anna Petusko, Frederick MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Cardiac failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive arteriosclerotic heart disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>7/31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/30</u> , 19 <u>56</u> , and that death occurred at <u>3:30A</u> M. from the causes and on the date stated above.							
SIGNATURE <u>James B. Thomas</u>				ADDRESS (Street, city, town, state) <u>Frederick, Md.</u>		DATE SIGNED <u>7/31/56</u>	
				M.D. <u>Frederick, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cem.</u>		LOCATION (City, town, or county) <u>Frostburg, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Ely Hicks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hofer</u>		ADDRESS <u>Cumberland Md</u>	

DATE AUG 3 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

67204

7209 CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH COUNTY Frederick MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick HOSPITAL OR INSTITUTION OR STREET ADDRESS Frederick Memorial Hosp. D.O.A.				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Florida COUNTY Palm Beach CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belle Glade STREET ADDRESS (If rural give location) 548 South West 4th Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Fannie Mae Potter				4. DATE OF DEATH (Month) (Day) (Year) July 4 1956			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 20, 1900	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crop Harvester		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Marianna, Florida		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ike Milton				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 152-16-1535		17. INFORMANT & ADDRESS Willie Oneal Jr. 548 South West 4th St. Belle Glade, Fla.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage ANTECEDENT CAUSE(S) DUE TO (B) Hypertension DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 3/4			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-16-56 , 19 56 to 7-3 , 19 56 , that I last saw the deceased alive on 7-3 , 19 56 , and that death occurred at 6:15 AM , from the causes and on the date stated above. SIGNATURE H. G. Baume Jr. M. D. ADDRESS (Street, city, town, state) Frederick, Md. DATE SIGNED 7-5-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF July 6-56		NAME OF CEMETERY OR CREMATORY Belle Glade		LOCATION (City, town, or county) (State) Palm Beach Co. Florida	
24. REC'D BY REGISTRAR DATE July 6, 1956		REGISTRAR'S SIGNATURE Elizabeth B. Heck		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles E. Hicks III Frederick, Md.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7240
CERTIFICATE OF DEATH

07205

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Braddock Heights				c. LENGTH OF STAY IN 1b 4 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent Home				d. STREET ADDRESS 24 East Third Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clara Middle D. Last Roser				4. DATE OF DEATH Month July Day 29 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23-1884		9. AGE (In years last birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin H. Davis				14. MOTHER'S MAIDEN NAME M.A.Rebecca Coblentz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Rockwell Terrace Mrs. Gilmore R. Flautt-Sr.- Frederick-Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho-Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. — p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 9, 1955 , to July 29, 1956 , that I last saw the deceased alive on July 25, 1956 , and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 East Church St.-Frederick-Md. DATE SIGNED 7/30/56							
ACTUAL SIGNATURE D. A. Pearre M.D.							
PHYSICIAN'S NAME (Type) Dr. A.A. Pearre							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-31-1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son				ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 31 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth B. Hark			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death		Place of Death		Cause of Death	
John A. Smith		Male		45		Jan 15, 1956		Home		Heart Disease	
Occupation		Education		Marital Status		Usual Residence		Place of Birth		Date of Birth	
Teacher		High School		Married		123 Main St, Baltimore, Md		Baltimore, Md		Jan 1, 1911	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 21

1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7241

CERTIFICATE OF DEATH

07296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 225 North Seton Ave				d. STREET ADDRESS 225 North Seton Ave.			
3. NAME OF DECEASED (Type or print) First John Middle Saffer Last Saffer				4. DATE OF DEATH Month July Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1867	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 27 Days 19 Hours 56 Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener	
10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Emmitsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? United State		
13. FATHER'S NAME Conrad Saffer				14. MOTHER'S MAIDEN NAME Margaret Elower			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Mary Saffer Address Emmitsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial degeneration DUE TO 422.1 Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 month year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 9 , 19 56 , to July 9 , 19 56 , that I last saw the deceased alive on July 9 , 19 56 , and that death occurred at 4:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles R. Williams M.D.				ADDRESS (Street, city or town, state) Emmitsburg Md DATE SIGNED July 28, 1956			
PHYSICIAN'S NAME (Type) CHARLES R. WILLIAMS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 56		22c. NAME OF CEMETERY OR CREMATORY St Joseph's Catholic		22d. LOCATION (City, town, or county) (State) Emmitsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison				ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR JUL 31 1956	
24b. REGISTRAR'S SIGNATURE A. H. Hedrich							

JUL 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07207

7242

CERTIFICATE OF DEATH

Reg. Dist. No.

134

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Emmitsburg,</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Emmitsburg,</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.D.# 1</u>		d. STREET ADDRESS <u>R.D.#1</u>	
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>Bernadette</u> Last <u>Sanders</u>		4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1885</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>George R. Sanders</u>		14. MOTHER'S MAIDEN NAME <u>Catherine R. Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Regis R. Sanders,</u> Address <u>Emmitsburg, R.D. 1 Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443A</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days several years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 30, 1956</u> to <u>July 22, 1956</u> , that I last saw the deceased alive on <u>July 21, 1956</u> , and that death occurred at <u>5 P</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. R. Cade</u>		M.D. <u>Emmitsburg Md</u>	
PHYSICIAN'S NAME (Type) <u>S. L. Allison</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 24, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Emmitsburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Allison</u>		ADDRESS <u>Emmitsburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jul 24 1956</u>		DATE <u>Jul 24 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>A. H. H. H. H.</u>			

BUREAU V. S.

JUL 24 1956

RECEIVED

7243

CERTIFICATE OF DEATH

07208

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monrovia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MONROVIA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) Ethel IRENE Shawbaker				4. DATE OF DEATH Month 7 Day 5 Year 1956			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 18-1890	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES C. FOGLE				14. MOTHER'S MAIDEN NAME MARTHA ELLEN BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT JACOB G. SHAWBAKER Address MONROVIA MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease 4 yrs. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							
INTERVAL BETWEEN ONSET AND DEATH 30 min							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 6/25 , 19 56 , to July 5 , 19 56 , that I last saw the deceased alive on 7/6/56 , and that death occurred at 7:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St DATE SIGNED 7/6/56 ACTUAL SIGNATURE Henry V Chase M.D. Henry V. Chase PHYSICIAN'S NAME (Type) Frederick Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 9-1956		22c. NAME OF CEMETERY OR CREMATORY MOUNT OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) FREDERICK MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Falconer Address New Market Md				24a. REC'D BY REGISTRAR DATE July 7-1956		24b. REGISTRAR'S SIGNATURE Lucian K. Falconer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FREDERICK

ALBANY

ETHEL TRACY

W

ALBANY

22 2 22

Acute Cardiac Failure
Arteriosclerotic Heart Disease

Hypertension

BUREAU V. S.

JUL 28-1956

RECEIVED

Handwritten notes and signatures, including "H. V. Chase" and "Fredrick".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7210
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home for the Aged		d. STREET ADDRESS 115 Record Street	
3. NAME OF DECEASED (Type or print) First Middle Last Rose Elizabeth Smallwood		4. DATE OF DEATH Month Day Year July 28- 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5-1871
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner		10b. KIND OF BUSINESS OR INDUSTRY Retail Millinery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Smallwood		14. MOTHER'S MAIDEN NAME Elizabeth Louise Rhinehart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Records-Home for the Aged- Frederick-Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Acute pulmonary edema (b) Arteriosclerotic heart dis. (c) with recurrent congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 57, to 28 July, 19 56 that I last saw the deceased alive on 14 July, 19 56, and that death occurred at 10:45 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Charles H. Conley, Jr.		M.D. Professional Bldg.	
PHYSICIAN'S NAME (Type) Dr. Charles H. Conley-Jr.		Frederick-Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-31-1956	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick- Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son		ADDRESS Frederick-Maryland	
24a. REC'D BY REGISTRAR DATE 31 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	

BUREAU V

1956 1 AUG

RECEIVED

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7211

CERTIFICATE OF DEATH

07210

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 42 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS 327 Braddock Avenue							
3. NAME OF DECEASED (Type or print) First GEORGE Middle WASHINGTON Last SMITH				4. DATE OF DEATH Month July Day 25 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 28, 1898	
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Baking Company			
13. FATHER'S NAME George Smith				14. MOTHER'S MAIDEN NAME Deborah Forman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2563		17. INFORMANT Mrs. Viola M. Smith, 327 Braddock Avenue, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia 490x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260x (b) Diabetes Mellitus (c) Arterio Sclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 25, 1956 , to July 25, 1956 , that I last saw the deceased alive on July 25, 1956 , and that death occurred at 6:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE H. F. Kline				M.D. North Market Street, Frederick, Md. DATE SIGNED 7/26/56			
PHYSICIAN'S NAME (Type) Dr. H. F. Kline Sr.				Same as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 27 July 1956	
				24b. REGISTRAR'S SIGNATURE Elizabeth S. Hock			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		45		1890	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		CERTIFICATE NO.		FILE NO.	
July 28, 1956		Home		12345		67890	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
[Signature]		[Signature]		July 28, 1956		Baltimore, Md.	

BUREAU V. 2

JUL 30 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 FilmG201 8-10-56 et

7244

CERTIFICATE OF DEATH

07211/38
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland Washington c. COUNTY Washington ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ijamsville rural		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital		d. STREET ADDRESS 645 Washington Ave	
3. NAME OF DECEASED (Type or print) First Charles Middle Clinton Last Snyder		4. DATE OF DEATH Month 7 Day 29 Year 56	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 11 1872
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Penna R.R. Retired		10b. KIND OF BUSINESS OR INDUSTRY near Williamsport Md	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Simon P. Snyder		14. MOTHER'S MAIDEN NAME Mary V. LeFevre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-9357	
17. INFORMANT Mrs Margaret Miller Hagerstown Md. R.#4		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.0 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-25 , 19 56 , to 7-29 , 19 56 , that I last saw the deceased alive on 7-29-56 , 19 56 , and that death occurred at 6:00 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Termer		DATE SIGNED 7-29-56	
PHYSICIAN'S NAME (Type) Gauseville Md		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/56	
22c. NAME OF CEMETERY OR CREMATORY Rose will Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Lucian Falconer		24b. REGISTRAR'S SIGNATURE Lucian Falconer	

AUG 3 1956

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

8/1/38

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JANUARY 5, 1903	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENNESSEE		ATTORNEY AT LAW		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		4:00 PM		101.0 F	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	

BUREAU V. S.

AUG 3 1958

RECEIVED

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN AND A REGISTRAR OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

7245

CERTIFICATE OF DEATH

Reg. Dist. No. 139

07212

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 684 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 125 N. Greene Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Earl First Middle Last Stage				4. DATE OF DEATH Month July Day 30 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/1895	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Night Watchman		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Stage				14. MOTHER'S MAIDEN NAME Matilda Leonard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 293-18-0622		17. INFORMANT Earl Stage Address 125 N. Greene Street Baltimore, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 9/15/ 19 54 to 7/30 19 56 , that I last saw the deceased alive on 7/30 19 56 , and that death occurred at 6:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>I. B. Lyon</i>		M.D. Cullen, Maryland		DATE SIGNED July 31, 1956			
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond Crago</i> <i>Ran Myers</i>		ADDRESS Thurmont, Maryland		24a. REC'D BY REGISTRAR DATE 7/31/56		24b. REGISTRAR'S SIGNATURE <i>I. B. Lyon</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. E.

AUG 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07213
Reg. Dist. No. 131

1. PLACE OF DEATH a. COUNTY Frederick 7212 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick c. LENGTH OF STAY IN 1b 12 Hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hotel Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Buchanan c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandon d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MERRILL Middle ADDISON Last STAINBROOK		4. DATE OF DEATH Month July Day 11 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Feb 1897
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist	11. BIRTHPLACE (State or foreign country) Iowa
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geologist		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Jacob Stainbrook		14. MOTHER'S MAIDEN NAME Adelide Towne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. 483-30-1229	
17. INFORMANT Stainbrook Address Ralph W. Stainbrook, Brandon, Iowa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Cardio Vascular Disease DUE TO (c) Hypertension CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE B. O. Thomas		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 July 1956	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24. NAME OF CEMETERY OR CREMATORY Brandon Cemetery	
24a. REC'D BY REGISTRAR 13 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth G. Heck	
25. LOCATION (City, town, or county) Brandon, Iowa		(State)	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth	
John		Male		27		White		1907		Maryland	
Occupation		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death	
Laborer		Heart Disease		Natural		Home		July 15		1956	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

JUL 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7213

CERTIFICATE OF DEATH

Reg. Dist. No. 131

07214

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial</u>				d. STREET ADDRESS <u>Thurmont</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Luther</u> Middle <u>J</u> Last <u>Staub</u>				4. DATE OF DEATH Month <u>7</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16. 1890 66 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Newton Staub</u>				14. MOTHER'S MAIDEN NAME <u>Annie Sweeney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-24-9760</u>			
17. INFORMANT <u>Molly Fuss</u> Address <u>Thurmont. MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO (b) <u>Coronary Heart Disease with recent coronary thrombosis</u> DUE TO (c) <u>Arteriosclerosis, generalized.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrene, Left Leg</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 mo</u> <u>? yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/13</u> , 19 <u>56</u> , to <u>7/11</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/10/56</u> , 19 <u>56</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry V Chase</u> M.D.				ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>7/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>				<u>Frederick Md</u>			
22a. BURIAL, CREMATION, RESURRECTION <u>Burial</u>				22b. DATE THEREOF <u>July 13. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ch. of God Cem.</u>	
22d. LOCATION (City, town, or county) <u>Creagerstown.</u> (State) <u>MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Creager</u> ADDRESS <u>Thurmont. MD</u>				24a. REC'D BY REGISTRAR <u>DATE 12 July 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		Male		45		April 10, 1900		April 15, 1956		Home		Heart Disease		Natural	
Occupation		Education		Marital Status		Usual Residence		Usual Place of Birth		Usual Place of Death		Usual Place of Burial		Usual Place of Interment	
Laborer		High School		Married		1234 Main St., Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.		Baltimore, Md.	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Investigator		Signature of Funeral Home		Signature of Burial Home		Signature of Interment Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Date of Registration		Date of Certification		Date of Final Review		Date of Final Approval		Date of Final Disposition		Date of Final Disposition		Date of Final Disposition	
July 13, 1956		July 13, 1956		July 13, 1956		July 13, 1956		July 13, 1956		July 13, 1956		July 13, 1956		July 13, 1956	

BUREAU V. 2

RECEIVED

July 13, 1956
Baltimore, MD

7214

CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS Feagaville			
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS GETZENDANNER STONE				4. DATE OF DEATH Month Day Year July 28, 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 24, 1901	
9. AGE (In years last birthday) yrs. 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Stone				14. MOTHER'S MAIDEN NAME Flora May Castle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-2444		17. INFORMANT Mr. Homer C. Stone, 629 Park Place, Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Miliary Tuberculosis 0120 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pott's disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH? 4 wks. 5 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 21, 1956 to July 28, 1956 , that I last saw the deceased alive on July 28, 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank D. Worthington				M.D. Professional Bldg., Frederick, Md. 7/30/1956			
PHYSICIAN'S NAME (Type) Dr. Frank D. Worthington				Sae as above			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery		22d. LOCATION (City, town, or county) (State) Feagaville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR 31 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

CERTIFICATE OF DEATH

187

BUREAU V. 2

• AUG 1 1956 •

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 16 Film G199 7-9-56 et

CERTIFICATE OF DEATH

07216

Reg. Dist. No. 131

7215

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NAOMI Middle MAE Last STRINE		4. DATE OF DEATH Month July Day 2 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1902
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. House		14. MOTHER'S MAIDEN NAME Minnie Crist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-14-7671	
17. INFORMANT Mr. Arthur Strine - Rt. 6 - Frederick, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Disease DUE TO (c) 1 day 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dispeptic Nephritis and Chronic Nephritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29, 1956 , to July 2, 1956 , that I last saw the deceased alive on July 1, 1956 , and that death occurred at 5:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. A. Pearre		M.D. 4 E Church St, Ind. Md. DATE SIGNED 7/3/56	
PHYSICIAN'S NAME (Type) Dr. A. A. Pearre		4 East Church Street - Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C E Cline & Son ADDRESS Frederick - Ind.		24a. REC'D BY REGISTRAR DATE 3 July 1956 24b. REGISTRAR'S SIGNATURE Elizabeth G. Hech	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
Mr. Frederick		Male		45		January 1, 1902		Maryland		Baltimore		Maryland		United States of America	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL OPINION		POST-MORTEM	
January 1, 1950		10:00 AM		Home		Heart Disease		Natural		Myocardial Infarction		No		No	
DATE OF INTERVIEW		NAME OF INTERVIEWER		TITLE OF INTERVIEWER		ADDRESS OF INTERVIEWER		CITY OF INTERVIEWER		STATE OF INTERVIEWER		COUNTRY OF INTERVIEWER		SIGNATURE OF INTERVIEWER	
January 1, 1950		Dr. J. H. Jones		Physician		123 Main St.		Baltimore		Maryland		United States of America		J. H. Jones	
DATE OF REPORT		NAME OF REPORTER		TITLE OF REPORTER		ADDRESS OF REPORTER		CITY OF REPORTER		STATE OF REPORTER		COUNTRY OF REPORTER		SIGNATURE OF REPORTER	
January 1, 1950		Dr. J. H. Jones		Physician		123 Main St.		Baltimore		Maryland		United States of America		J. H. Jones	

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JUL 5 1956
BUREAU V. 8

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7246

CERTIFICATE OF DEATH

07217

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodsboro				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodsboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Abraham Last Stultz			4. DATE OF DEATH Month July Day 2 Year 19 56				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1867		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 2 Days 7 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Taneytown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin Stultz				14. MOTHER'S MAIDEN NAME Ellen (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Nettie Stottlemeyer, Woodsboro, Md.			
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 Mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 2, 1953 to July 2, 1956 , that I last saw the deceased alive on July 1, 1956 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Julius Chepko			M.D. 85 1/2 W. Green St			DATE SIGNED 7/3/56	
PHYSICIAN'S NAME (Type) Julius Chepko			ADDRESS (Street, city or town, state) Westminster, Md				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/56		22c. NAME OF CEMETERY OR CREMATORY Church of Brethern		22d. LOCATION (City, town, or county) (State) Rocky Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager				24a. REC'D BY REGISTRAR Thurmont, Md.		24b. REGISTRAR'S SIGNATURE J. H. Hedrick	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
Frederick		35 yrs.		Male		White	
Place of Birth		Date of Birth		Date of Death		Time of Death	
Woodboro		April 22, 1887		April 22, 1922		10:30 A.M.	
Cause of Death		Place of Death		Occupation		Signature of Physician	
Tuberculosis		Tarrytown, Md.		Physician		Franklin Smith	
Signature of Informant		Relationship		Signature of Physician		Signature of Registrar	
Mrs. Ella Stollenwerfer, Woodboro, Md.		Wife		None		None	

Central Pharmacy

July 1, 1922

James H. Hinkle

July 1, 1922

July 1, 1922

RECEIVED

BUREAU V. S.

JUL 5 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG200 7-19-56 et

CERTIFICATE OF DEATH

07218

Reg. Dist. No. 139

7247

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 235 South Duncan Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hugo Middle Stumpf Last Stumpf				4. DATE OF DEATH Month 7 Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1888	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 3 Days 01 Hours 4 Min.		IF UNDER 24 HRS. Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer				10b. KIND OF BUSINESS OR INDUSTRY Labor		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-05-9571 A		17. INFORMANT Address Mrs. Julia Stumpf, wife, 235 S. Duncan St. Baltimore, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 12 , 19 56 , to July 13 , 19 56 , that I last saw the deceased alive on July 13 , 19 56 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Maryland DATE SIGNED 7/13/56							
ACTUAL SIGNATURE I. B. Lyon M.D.							
PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.							
22a. BURIAL, CREMATION, REMOVAL, SPECIFY		22b. DATE THEREOF 7/16/56		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE William Tealkowski				ADDRESS 2007 Eastern Ave Baltimore Md.		24a. REC'D BY REGISTRAR DATE 7/13/56	
				24b. REGISTRAR'S SIGNATURE I. B. Lyon			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7248

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen				c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxen Hill 16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 5748 Livingston Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle C. Last Treese				4. DATE OF DEATH Month 7 Day 12 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/6/1913	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Steele Smith				14. MOTHER'S MAIDEN NAME Mary Ann Dublin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alice C. Treese Address 5748 Livingston Road, Oxen Hill, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 7/5/1956 , 19____, to 7/12/56 , 19____, that I last saw the deceased alive on 7/12/56 , 19____, and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Frederick Co., Md. DATE SIGNED 7/12/56 ACTUAL SIGNATURE I. B. Lyon M.D. I. B. Lyon, M.D. PHYSICIAN'S NAME (Type) I. B. Lyon, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/16/56		22c. NAME OF CEMETERY OR CREMATORY New St. Mary's		22d. LOCATION (City, town, or county) (State) Hollidaysburg	
23. FUNERAL DIRECTOR'S SIGNATURE Walter F. Stone Kylesboro, Penna.				24a. REC'D BY REGISTRAR DATE 7/12/56		24b. REGISTRAR'S SIGNATURE I. B. Lyon	

RECEIVED

7249

CERTIFICATE OF DEATH

Reg. Dist. No. 139

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Frederick	MARYLAND	STATE Maryland	COUNTY Balto. Co.
CITY (If outside corporate limits, write RURAL) Cullen	LENGTH OF STAY (in this place) 42 days	CITY (If outside corporate limits, write RURAL and give nearest town) Near Raspeburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Victor Cullen State Hospital		STREET ADDRESS (If rural give location) 7505 Kenlea Ave.	
3. NAME OF DECEASED: (First) Henry (Middle) Ferdinand (Last) Trenkamp		4. DATE (Month) (Day) (Year) OF DEATH: 7 2 19 56	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, DIVORCED, WIDOWED, (Specify) Divorced	8. DATE OF BIRTH: 8/24/1906
9. AGE last birthday 49 yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor		10B. KIND OF BUSINESS OR INDUSTRY: laborer	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Henry Trenkamp		14. MOTHER'S MAIDEN NAME: ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-03-1285	
17. INFORMANT & ADDRESS: Mr. Henry F. Trenkamp		7505 Kenlea Ave., Raspeburg, Balto. Co., Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			3 months
(A) IMMEDIATE CAUSE Carcinoma of lung			
(B) ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/21/56 , to 7/2/56 , that I last saw the deceased alive on 7/2/56 , and that death occurred at 1:20 PM , from the causes and on the date stated above.			
SIGNATURE [Signature]		M. D. Cullen, Maryland DATE SIGNED 7/2/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF July 5, 1956 NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery LOCATION (City, town, or county) (State) O'Donnell St., Balto, Md.	
DATE REC'D BY LOCAL REGISTRAR 7/2/56		REGISTRAR'S SIGNATURE [Signature] 24. FUNERAL DIRECTOR ADDRESS Dippel Bors., 1800 E. Lombard St.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 5 1956

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07221

Reg. Dist. No. 131

7216

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>426 Carroll parkway</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Gough</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1873</u>
9. AGE (In years (last birthday)) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>operator jewelry store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Turner</u>		14. MOTHER'S MAIDEN NAME <u>Isabella McComas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>349-10-3165</u>	
17. INFORMANT <u>Mrs Elsie May Turner</u>		Address <u>Frederick, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>B. O. Thomas</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>B. O. Thomas</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>7-9-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>
22d. LOCATION (City, town, or county) <u>Washington - D. C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Cline & Son - Frederick - Md.</u>		24a. REC'D BY REGISTRAR <u>Elizabeth B. Hark</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>9 July 1956</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for use by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JUL 10 1956		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HIGH SCHOOL		MARRIED		HEART DISEASE		NATURAL	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY	
JAN 15 1911		BALTIMORE, MARYLAND		JUL 10 1956		JUL 10 1956		JUL 10 1956		JUL 10 1956	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JUL 10 1956		BALTIMORE, MARYLAND		JUL 10 1956		BALTIMORE, MARYLAND		JUL 10 1956		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JUL 10 1956		BALTIMORE, MARYLAND		JUL 10 1956		BALTIMORE, MARYLAND		JUL 10 1956		BALTIMORE, MARYLAND	

RECEIVED
 JUL 10 1956
 BUREAU V. S.

7217
CERTIFICATE OF DEATH

Reg. Dist. No.

07222
131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick Memorial Hosp.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1956</u>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>A</u> Last <u>Wastler</u>	5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>1/13/73</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel A. Six</u>		14. MOTHER'S MAIDEN NAME <u>Lucricia Staley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ethel Fry</u>		Address <u>Thurmont, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/17</u> 19 <u>56</u> , to <u>7/19</u> 19 <u>56</u> , that I last saw the deceased alive on <u>7/19</u> 19 <u>56</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D.		ADDRESS (Street, city or town, state) <u>4 E. Church St</u> DATE SIGNED <u>7/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Henry V. Chase</u>		<u>Frederick Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Thurmont Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond B. [unclear]</u> ADDRESS <u>Thurmont, Md.</u>		24a. REC'D BY REGISTRAR <u>23 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Ely B. Heck</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		68		JUL 10 1887		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
RETIRED		HEART DISEASE		NATURAL		2 WEEKS		JUL 28 1956		BALTIMORE		MD		USA	
FAMILY PHYSICIAN		HOSPITAL		NAMES OF PHYSICIANS		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
DR. J. H. HARRIS		BALTIMORE HOSPITAL		DR. J. H. HARRIS		JUL 28 1956		JUL 28 1956		JUL 28 1956		JUL 28 1956		JUL 28 1956	
FAMILY PHYSICIAN		HOSPITAL		NAMES OF PHYSICIANS		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
DR. J. H. HARRIS		BALTIMORE HOSPITAL		DR. J. H. HARRIS		JUL 28 1956		JUL 28 1956		JUL 28 1956		JUL 28 1956		JUL 28 1956	

BUREAU A. H.

JUL 28 1956

RECEIVED

Blue Ridge Laboratory

LABORATORY

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07223

7250

CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick-Rural-R.D.#4</u>				c. LENGTH OF STAY IN 1b <u>Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sunnyside</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CECELIA</u> Middle <u>FRANCES</u> Last <u>WEEDON</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25, 1898</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Scott</u>				14. MOTHER'S MAIDEN NAME <u>Martha Timbers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Daniel I. Weedon, 127 1/2 W. All Saints St., Frederick, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>Unknown</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>7/3</u> , 19 <u>56</u> , to <u>7/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/4</u> , 19 <u>56</u> , and that death occurred at <u>9:30A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James B. Thomas</u>		M.D. <u>North Market Street, Frederick, Md.</u>		DATE SIGNED <u>7/6/1956</u>			
PHYSICIAN'S NAME (Type) <u>Dr. James B. Thomas</u>		Same as above					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 7, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyside Methodist Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick County, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & SON, Frederick, Maryland</u> ADDRESS			24a. REC'D BY REGISTRAR <u>July 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Elizabeth L. Hark</u>			

1956 6 JUL

RECEIVED

7222

CERTIFICATE OF DEATH

Reg. Dist. No.

141

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glennmerrie Nursing Home		d. STREET ADDRESS 1944 Seminary Place	
3. NAME OF DECEASED (Type or print) First James Middle Artemus Last WHITLOCK		4. DATE OF DEATH Month July Day 31 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1869
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months 4 Days 5	IF UNDER 24 HRS. Hours 5 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer-Self-emp.	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John A. Whitlock	
14. MOTHER'S MAIDEN NAME Mary L. Hamm		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Ruth Whittemore-Same Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - rectum DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 10, 1954 , to 7-31-1956 , that I last saw the deceased alive on 7-21-1956 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 8-16-56 ACTUAL SIGNATURE Dr. Charles Pruett M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/1956	22c. NAME OF CEMETERY OR CREMATORY Rockville Union	22d. LOCATION (City, town, or county) (State) Rockville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR DATE AUG 15 1956	24b. REGISTRAR'S SIGNATURE Burgess Burke

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME OF DECEASED John A. Whitlock		DATE OF BIRTH 03/23/1883		SEX Male	
RACE White		MARRIAGE Married		EDUCATION High School	
PLACE OF BIRTH Virginia		DATE OF DEATH 08/15/1956		CAUSE OF DEATH Heart Disease	
OCCUPATION Farmer		PLACE OF DEATH Home		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)	

BUREAU V. E.

AUG 15 1956

RECEIVED

RECEIVED
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
WASHINGTON, D.C. 20462

7218
CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY FREDERICK MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY FREDERICK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK				c. LENGTH OF STAY IN 1b 42 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL				d. STREET ADDRESS THURMONT			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ALLEN Middle John Last WILLIAR				4. DATE OF DEATH Month July Day 7 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-2-71	
9. AGE (In years last birthday) 85 yrs.		10. UNDER 1 YEAR Months 8 Days 5 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY Dept. Store.			
13. FATHER'S NAME Martin A. Williar				14. MOTHER'S MAIDEN NAME Savannah Weller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. No			
17. INFORMANT Elsie M. Williar. Thurmont. MD				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS WITH MASSIVE INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC CYSTITIS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAY 26, 1956, to JULY 7, 1956 , that I last saw the deceased alive on JULY 7, 1956 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. A. Pearre M.D. Fredrick, Md.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) A. A. Pearre							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 10, 1956		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cem. Co Baltimore MD.	
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Beagan ADDRESS Thurmont Md.				24a. REC'D BY REGISTRAR DATE 9 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heck	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

UL 10 1956

RECEIVED

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07225

CERTIFICATE OF DEATH

Reg. Dist. No. 131

7219

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				c. LENGTH OF STAY IN 1b 12 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Leslie) First Middle Last Leslie Brunner YOUNG				4. DATE OF DEATH Month July Day 1 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Sept 1879	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sampson L. Young				14. MOTHER'S MAIDEN NAME Samantha E. Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT 306 North College Parkway, Frederick, Maryland Samuel H. Young,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis Aorta, distal 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 55 , to 1 July , 19 56 , that I last saw the deceased alive on 1 Feb , 19 56 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 W 3rd St DATE SIGNED 7-1-56							
ACTUAL SIGNATURE Thomas E Stone		M.D. 4 W 3rd St		PHYSICIAN'S NAME (Type) Thomas E STONE 4 W. 3rd St., Frederick, Md. 7/1/56			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 5 July 1956		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE 22 July 1956		24b. REGISTRAR'S SIGNATURE Elizabeth B. Heise	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. BASTINORE		45		M		W		JAN 1 1910		BALTIMORE		BALTIMORE		MARYLAND	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		JAN 1 1935		BALTIMORE		BALTIMORE		MARYLAND		JAN 1 1935		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
HEART DISEASE		JUL 3 1956		BALTIMORE		BALTIMORE		MARYLAND		JUL 3 1956		BALTIMORE		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		CITY		COUNTRY		DATE OF MANNER		PLACE OF MANNER		CITY OF MANNER	
NATURAL		JUL 3 1956		BALTIMORE		BALTIMORE		MARYLAND		JUL 3 1956		BALTIMORE		BALTIMORE	
OCCUPATION		DATE		PLACE		CITY		COUNTRY		DATE OF OCCUPATION		PLACE OF OCCUPATION		CITY OF OCCUPATION	
LABORER		JUL 3 1956		BALTIMORE		BALTIMORE		MARYLAND		JUL 3 1956		BALTIMORE		BALTIMORE	
EDUCATION		DATE		PLACE		CITY		COUNTRY		DATE OF EDUCATION		PLACE OF EDUCATION		CITY OF EDUCATION	
HIGH SCHOOL		JUL 3 1956		BALTIMORE		BALTIMORE		MARYLAND		JUL 3 1956		BALTIMORE		BALTIMORE	
RELIGION		DATE		PLACE		CITY		COUNTRY		DATE OF RELIGION		PLACE OF RELIGION		CITY OF RELIGION	
CATHOLIC		JUL 3 1956		BALTIMORE		BALTIMORE		MARYLAND		JUL 3 1956		BALTIMORE		BALTIMORE	
SIGNED BY		DATE		PLACE		CITY		COUNTRY		DATE OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE	
JAMES H. BASTINORE		JUL 3 1956		BALTIMORE		BALTIMORE		MARYLAND		JUL 3 1956		BALTIMORE		BALTIMORE	

BUREAU V. 3

JUL 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7251

CERTIFICATE OF DEATH

Reg. Dist. No. 136

07226

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Walkersville</u>				c. LENGTH OF STAY IN 1b <u>68 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural Walkersville</u>			
3. NAME OF DECEASED (Type or print) <u>CLAYTON MAYNARD ZIMMERMAN</u>				4. DATE OF DEATH <u>July 19 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1867</u>	9. AGE (In years last birthday) <u>89</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Ephraim I. Zimmerman</u>				14. MOTHER'S MAIDEN NAME <u>Maria Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. Clayborne Zimmerman, Walkersville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right hip, healed & metal pin to immobilize</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 July 1956</u> to <u>19 July 1956</u> , that I last saw the deceased alive on <u>19 July 1956</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Stoner, Jr.</u> M.D.				DATE SIGNED <u>20 July 1956</u>			
PHYSICIAN'S NAME (Type) <u>JAMES E. STONER, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. C. Barton</u> ADDRESS <u>Walkersville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 23 July 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth G. Fitch</u>	

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>Wisconsin</i></p>	
<p>5. Date of death: <i>Dec 15, 1956</i></p>		<p>6. Place of death: <i>Home</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Immediate cause: <i>Myocardial Infarction</i></p>	
<p>9. Duration of illness: <i>2 weeks</i></p>		<p>10. Usual place of abode: <i>Home</i></p>	
<p>11. Name of attending physician: <i>Dr. J. H. Smith</i></p>		<p>12. Name of medical examiner: <i>Dr. J. H. Smith</i></p>	
<p>13. Name of funeral home: <i>John Doe & Co.</i></p>		<p>14. Name of cemetery: <i>St. Mary's</i></p>	
<p>15. Name of informant: <i>John Doe</i></p>		<p>16. Name of informant: <i>John Doe</i></p>	
<p>17. Name of informant: <i>John Doe</i></p>		<p>18. Name of informant: <i>John Doe</i></p>	
<p>19. Name of informant: <i>John Doe</i></p>		<p>20. Name of informant: <i>John Doe</i></p>	
<p>21. Name of informant: <i>John Doe</i></p>		<p>22. Name of informant: <i>John Doe</i></p>	
<p>23. Name of informant: <i>John Doe</i></p>		<p>24. Name of informant: <i>John Doe</i></p>	
<p>25. Name of informant: <i>John Doe</i></p>		<p>26. Name of informant: <i>John Doe</i></p>	
<p>27. Name of informant: <i>John Doe</i></p>		<p>28. Name of informant: <i>John Doe</i></p>	
<p>29. Name of informant: <i>John Doe</i></p>		<p>30. Name of informant: <i>John Doe</i></p>	
<p>31. Name of informant: <i>John Doe</i></p>		<p>32. Name of informant: <i>John Doe</i></p>	
<p>33. Name of informant: <i>John Doe</i></p>		<p>34. Name of informant: <i>John Doe</i></p>	
<p>35. Name of informant: <i>John Doe</i></p>		<p>36. Name of informant: <i>John Doe</i></p>	
<p>37. Name of informant: <i>John Doe</i></p>		<p>38. Name of informant: <i>John Doe</i></p>	
<p>39. Name of informant: <i>John Doe</i></p>		<p>40. Name of informant: <i>John Doe</i></p>	
<p>41. Name of informant: <i>John Doe</i></p>		<p>42. Name of informant: <i>John Doe</i></p>	
<p>43. Name of informant: <i>John Doe</i></p>		<p>44. Name of informant: <i>John Doe</i></p>	
<p>45. Name of informant: <i>John Doe</i></p>		<p>46. Name of informant: <i>John Doe</i></p>	
<p>47. Name of informant: <i>John Doe</i></p>		<p>48. Name of informant: <i>John Doe</i></p>	
<p>49. Name of informant: <i>John Doe</i></p>		<p>50. Name of informant: <i>John Doe</i></p>	
<p>51. Name of informant: <i>John Doe</i></p>		<p>52. Name of informant: <i>John Doe</i></p>	
<p>53. Name of informant: <i>John Doe</i></p>		<p>54. Name of informant: <i>John Doe</i></p>	
<p>55. Name of informant: <i>John Doe</i></p>		<p>56. Name of informant: <i>John Doe</i></p>	
<p>57. Name of informant: <i>John Doe</i></p>		<p>58. Name of informant: <i>John Doe</i></p>	
<p>59. Name of informant: <i>John Doe</i></p>		<p>60. Name of informant: <i>John Doe</i></p>	
<p>61. Name of informant: <i>John Doe</i></p>		<p>62. Name of informant: <i>John Doe</i></p>	
<p>63. Name of informant: <i>John Doe</i></p>		<p>64. Name of informant: <i>John Doe</i></p>	
<p>65. Name of informant: <i>John Doe</i></p>		<p>66. Name of informant: <i>John Doe</i></p>	
<p>67. Name of informant: <i>John Doe</i></p>		<p>68. Name of informant: <i>John Doe</i></p>	
<p>69. Name of informant: <i>John Doe</i></p>		<p>70. Name of informant: <i>John Doe</i></p>	
<p>71. Name of informant: <i>John Doe</i></p>		<p>72. Name of informant: <i>John Doe</i></p>	
<p>73. Name of informant: <i>John Doe</i></p>		<p>74. Name of informant: <i>John Doe</i></p>	
<p>75. Name of informant: <i>John Doe</i></p>		<p>76. Name of informant: <i>John Doe</i></p>	
<p>77. Name of informant: <i>John Doe</i></p>		<p>78. Name of informant: <i>John Doe</i></p>	
<p>79. Name of informant: <i>John Doe</i></p>		<p>80. Name of informant: <i>John Doe</i></p>	
<p>81. Name of informant: <i>John Doe</i></p>		<p>82. Name of informant: <i>John Doe</i></p>	
<p>83. Name of informant: <i>John Doe</i></p>		<p>84. Name of informant: <i>John Doe</i></p>	
<p>85. Name of informant: <i>John Doe</i></p>		<p>86. Name of informant: <i>John Doe</i></p>	
<p>87. Name of informant: <i>John Doe</i></p>		<p>88. Name of informant: <i>John Doe</i></p>	
<p>89. Name of informant: <i>John Doe</i></p>		<p>90. Name of informant: <i>John Doe</i></p>	
<p>91. Name of informant: <i>John Doe</i></p>		<p>92. Name of informant: <i>John Doe</i></p>	
<p>93. Name of informant: <i>John Doe</i></p>		<p>94. Name of informant: <i>John Doe</i></p>	
<p>95. Name of informant: <i>John Doe</i></p>		<p>96. Name of informant: <i>John Doe</i></p>	
<p>97. Name of informant: <i>John Doe</i></p>		<p>98. Name of informant: <i>John Doe</i></p>	
<p>99. Name of informant: <i>John Doe</i></p>		<p>100. Name of informant: <i>John Doe</i></p>	

RECEIVED
JUL 24 1956
BUREAU V. S.